Health Plan of San Joaquin | Mountain Valley Health Plan

New Contracted Provider Orientation

Medicare Advantage D-SNP

In-Service - 12/10/2025

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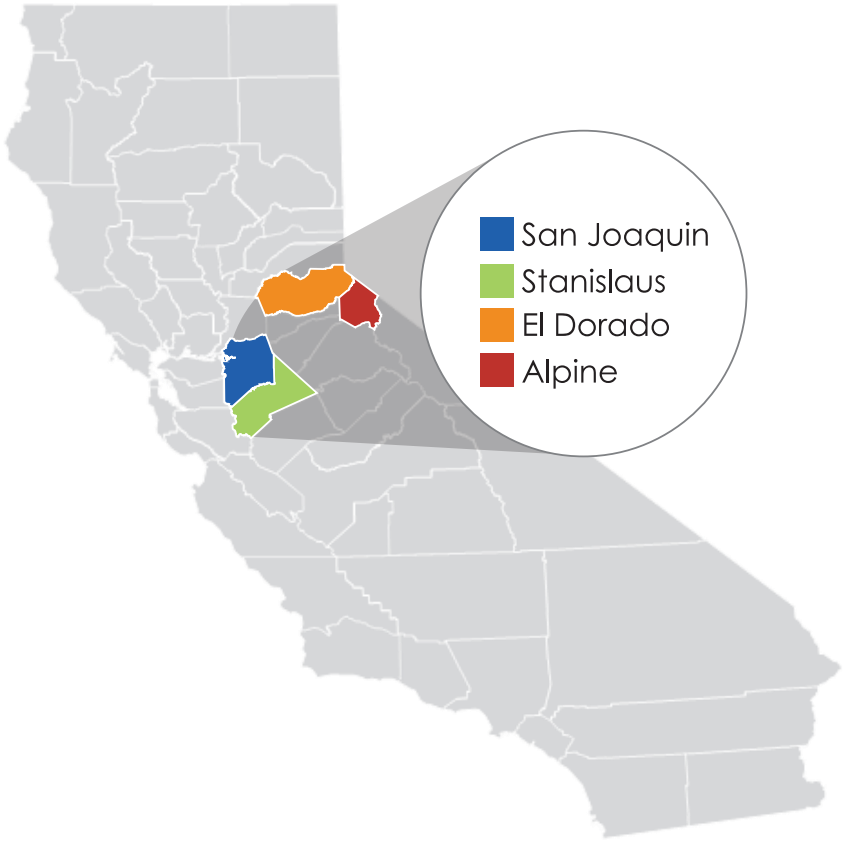
BACKGROUND



In 1996, the Health Commission established Health Plan of San Joaquin (HPSJ) as a local Medi-Cal managed care plan to
meet the unique health care needs in San Joaquin County.

In 2013, DHCS selected HPSJ to serve people who qualify for Medi-Cal in Stanislaus County, increasing member access to a larger, combined provider network.

In 2024, the Health Commission expanded to serve Alpine and El Dorado counties as Mountain Valley Health Plan (MVHP) to align with the mission of public health plan models (called local initiatives).

In 2026, Health Plan will offer a Dual-Eligible Special Needs Plan (DSNP) for people who qualify for both Medi-Cal and Medicare.

We serve over 400,000 Medi-Cal beneficiaries.

Locations:

French Camp (HQ)
San Joaquin County

Modesto
Stanislaus County

Placerville
El Dorado County

Mission Driven and Community Focused

Our Vision

Healthy communities with equitable access to quality care.

Our Mission

Provide high quality healthcare for our members through community partnerships.

Our Values

Accountability
We are accountable to members, providers, our communities, and each other.

Diversity, Equity, and Inclusion (DEI)
We believe in promoting a foundation of compassion and respect for diversity, equity, and inclusion strengthening our organization and community by embracing opportunities for growth and leveraging the uniqueness of individual ideas, thoughts, and cultures.

Partnerships
We actively engage in community partnerships to advance quality care and health equity.

Stewardship
We serve as a responsible steward of entrusted resources.

Excellence
We act with integrity and aim for excellence in all we do.

Teamwork
We demonstrate teamwork in all our interactions.

Medicare Advantage D-SNP

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO) ("Advantage D-SNP") is for people with both Medicare (Part A and B) and Medi-Cal, with mandatory enrollment for Medi-Cal benefits, including Long-Term Services and Supports (LTSS) benefits and Medicare benefits.

Member eligibility

- Live in our service area; San Joaquin, Stanislaus, El Dorado, and Alpine counties
- Are age 21 and older at the time of enrollment **and**
- Have both Medicare Part A and Part B **and**
- Are currently eligible for Medi-Cal **and**
- Are a full-benefit dual eligible beneficiary **and**
- Enroll in Advantage D-SNP for Medicare benefits and HPSJ/MVHP for Medi-Cal benefits. This is known as "Exclusively Aligned Enrollment" **and**
- Are a United States citizen or are lawfully present in the U.S.

Benefits Include

- Medicare-covered benefits include Parts A, B & D
  - **Medicare Part A** (Hospital Insurance) helps pay for inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also helps cover hospice care and some home health care.
  - **Medicare Part B** (Medical Insurance) helps cover 2 types of services:
    1. Medically necessary services: Services or supplies that meet accepted standards of medical practice to diagnose or treat your medical condition.
    2. Preventive Services: (https://www.medicare.gov/coverage/preventive-screening-services):
  - **Medicare Part D** (Prescription Drug coverage) helps pay for the brand-name and generic drugs.
- Medi-Cal benefits listed in the State Medicaid Agency Contract
- Supplemental benefits

Premiums/copayments*/coinsurance are paid by the state on behalf of the member. Members will pay nothing for covered medical services as long as plan rules are followed.

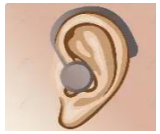
*Exception: Members may be responsible for Part D Low-Income Subsidy cost shares.

Covered Services (Dual benefits)

- Medi-Cal benefits can be found at https://www.hpsj.com/summary-of-benefits/
- Medicare D-SNP benefits can be found at https://www.hpsj-mvhp.org
- Centers for Medicare & Medicaid Services, Medicare Coverage can be found at https://www.cms.gov/

*Dental benefits are obtained through Denti-Cal.

D-SNP Supplemental Benefits



Hearing Aids

Up to $1500 above the state Medi-Cal limit of $1,510 per year for hearing aids, molds, modifications and accessories. Total benefit applies to either or both ears.

Over the Counter Products

$150 quarterly allowance per quarter (every 3 months), to purchase OTC items and supplies at retail stores, through the OTC mail-order catalog, or our vendor's website.

Vision Care

Access to large network of optometrists through the Vision Care Provider Network. Benefits include

- a routine eye exam per year
- Base lenses (single vision, lined bifocal, lined trifocal, lenticular- up to one pair every two years) and $300 toward eyeglass frames or $115 toward contact lenses.

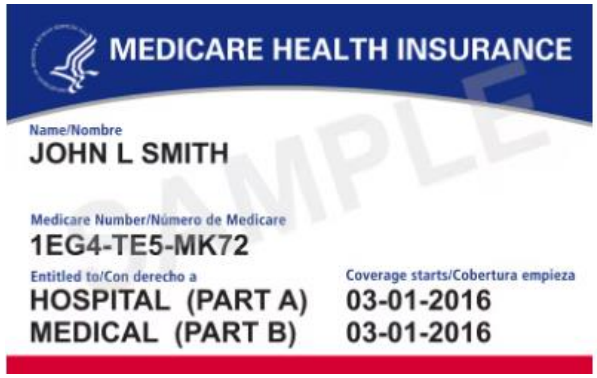
Member Eligibility Identification Cards

Health Plan members have three ID cards. The Medi-Cal Benefits Identification card (BIC) issued by the State of California, the Medicare Identification card, and Advantage D-SNP ID Card.

Health Plan Member Identification Card

Medi-Cal Beneficiary Identification Card (BIC)

Medicare Identification Card



Member Eligibility Verification – Health Plan

Providers may verify Advantage D-SNP member eligibility through the following resources:

- **By logging into**
  - Advantage D-SNP's secure provider portal, DRE, at https://www.hpsj.com/providers/

- To receive access to DRE, Providers must complete the online request form: https://provider.hpsj.com/public/acctdre/default.aspx

- **By calling Advantage D-SNP Customer Service Department**
  - 1-888-361-PLAN (7526)
    - **Hours of Operation:** 8:00 a.m. to 8:00 p.m.
      Mon – Sun October 1 through – 31
    - Mon – Fri April 1 – September 30

- **By calling Interactive Voice Response (IVR)**
  - 200-942-6303 (Available 24/7)

Member Eligibility Verification – Medi-Cal

Providers may verify Health Plan Member eligibility through the following resources:

Automated Eligibility Verification System (AEVS)

- **AEVS Enrollment Requirements** – All new fee-for-service providers must register in the
  - Provider Portal link https://provider-portal.apps.prd.cammis.medi-cal.ca.gov/email .
  - You must have an NPI and a registration token.
  - Registration tokens for fee-for-service providers were sent to the pay-to-address on file with Medi-Cal.
  - If a token was not received, providers can call the Telephone Service Center (TSC) at 1-800-541-5555 to request a new registration token.

Provider Rights

Providers have the right to know what they can expect from the Health Plan; Provider Rights include, but are not limited to, the following:

- ❑ New Provider Orientation
- ❑ Communication with Members
- ❑ Review of Credentialing Information
- ❑ Correction of Credentialing Information
- ❑ Credentialing Updates
- ❑ Staying Informed
- ❑ Coordination of Care
- ❑ Health Plan Support
- ❑ Health Plan Contact Information
- ❑ Health Plan Communications
- ❑ Grievance and Appeals

Provider Manual Section 5 Provider Services:
2026-Medicare Advantage D-SNP Provider-Manual-HPSJ-MVHP.pdf

Provider Responsibilities

Providers are responsible for complying with various business operational standards while working with Advantage D-SNP. These standards and responsibilities are further outlined in the Provider Agreement and include, but are not limited to, the following:

- ❑ Provider Manual
- ❑ Policies and Procedures
- ❑ Governmental Regulations
- ❑ Committee Participation
- ❑ Medical Record Access and Confidentiality
- ❑ Panel Status- All Network Providers must notify Health Plan in writing within five business (5) days of closing the practice(s) to new Members
- ❑ Performance Data
- ❑ Completing all CMS/DHCS/Advantage D-SNP mandated trainings
- ❑ Continuity Of Care – Obligations of Terminating Providers (See *Provider Termination Section within this document.)*
- ❑ Ensuring Providers have Accurate Contact Information for Members and Network Providers Involved in Members' Care.

Provider Directory Maintenance Responsibility

It's important that Providers comply with providing timely information to maintain an accurate Provider Directory. Health Plan has a regulatory responsibility to publish an accurate Directory of all Providers.

In accordance with state and federal law, including CA Health and Safety Code 1367.27, providers are required to **validate their information at least every 6 months** and update the provider directory as often as necessary to ensure accurate information is available for our members.

You can update your demographic information by:

- Emailing- providernetworks.verification@hpsj.com
- Fax -209-933-3700
- By selecting the Provider Verification link in DRE (Under Welcome Provider)
- Submitting the Advantage D-SNP Roster Template
  The **Health Plan Roster Template** is available on our website: https://www.hpsj.com/forms-documents/
    - Attestation Form (1st Tab – required)
    - Health Plan Roster Template (select the "Tab" that suits your provider type)

Provider Directory Maintenance Responsibility – Cont.

Providers must inform Advantage D-SNP timely when any of the following occur:

- Provider is no longer accepting new Members
- Provider was previously not accepting new Members but is now open to new Members
- Provider has moved to a different location
- Provider has added a location
- Provider has changed its office hours
- A change in languages spoken in the office
- Any other information affecting the accuracy of the Provider Directory

Failure to update your information will delay payment or reimbursement of claim(s), pursuant to California Code, Health and Safety Code – HSC § 1367.27 subdivision (p)(1), including removal from the provider directory.

For Provider Directory Information, visit Health Plan's website at **https://www.hpsj.com/find-a-provider/**

Provider Termination

All network providers who terminate without cause must give Advantage D-SNP one hundred and twenty (120) days advance written notice. This includes providers leaving the Practice or Medical Group.

In addition, it is critical that providers comply with the specific termination provisions and notice periods outlined in their signed agreements.

It is recommended that providers and medical groups with member assignment terminate at the end of the month to coordinate member care appropriately. This doesn't absolve the provider from providing a minimum advanced notice of 120 days.

Provider Alerts and Updates

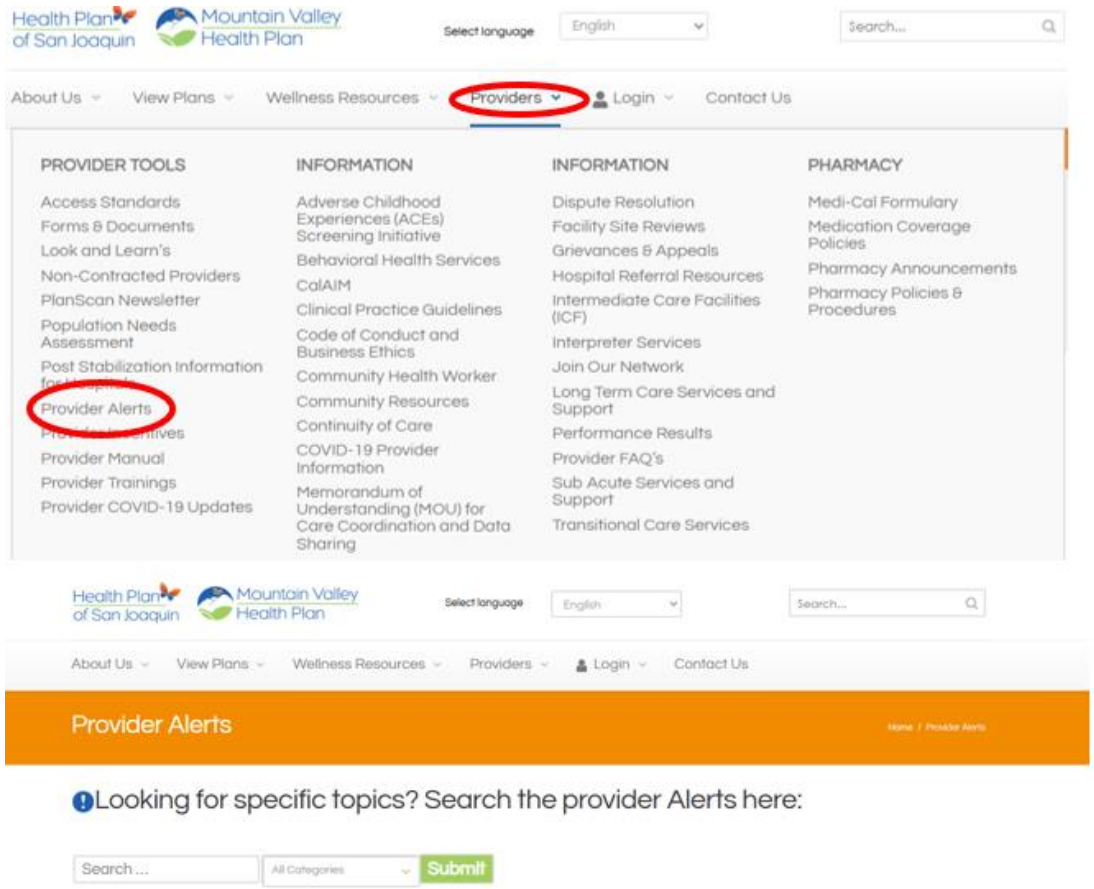
Provider Alerts and Updates

- ❑ Benefits Changes
- ❑ Formulary Changes
- ❑ Trainings
- ❑ CME/CEU
- ❑ Provider Presentations

Methods of Delivery

- ❑ Via Fax
- ❑ Posted in DRE
- ❑ Posted to the website

https://www.hpsj.com/alerts/



Secure Methods for Sharing Information

Providers and Health Plan must comply with Health Insurance Portability and Accountability Act (HIPAA) requirements. To keep protected information secure, Advantage D-SNP has the following options for submitting Protected Health Information (PHI):

- Encrypted emails
- Secure File Transfer Protocol (sFTP)
- Doctors Referral Express (DRE) *Secure Provider Portal*
- File Exchange Secure Portal – For specific inbound and outbound data reports

Patient Rights & Responsibilities

Health Plan acknowledges the importance of member rights and responsibilities and providers' responsibility to carry out its functions in accordance with fundamental obligations to improve patient outcomes. To learn more about Patients' Rights and Responsibilities, click on the link below.
https://www.hpsj.com/rights-responsibilities/

Patients are provided a written copy of their **Patient Rights and Responsibilities** in their Evidence of Coverage (EOC) package, which they receive when joining Advantage D-SNP.

Please note that Medi-Cal members **cannot** be billed for covered services, including missed appointments.

Timely Access Standards

Health Plan is required to monitor access and availability within the network, ensuring Network Providers observe access standards. Any deficiencies within our providers may lead to corrective action(s).

Sometimes, waiting longer for care is not a problem. A provider may give a longer wait time if it would not harm the member's health. It must be noted in the member's record that a longer wait time will not be harmful to their health.

Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers.

Timely Access Resources:
DHCS All Plan Letter 23-001 https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
DMHC Timely Access to Care Fact Sheet
https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx

Timely Access Standards

Types of Services	Standard
Non-urgent primary care appointments	Within 10 business days of request
Non-urgent appointments with a specialist	Within 15 business days of request
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of request
Non-urgent mental health (non-physician) appointments	Within 10 business days of request
Urgent Access to PCP or designee	24 hours a day, 7 days a week appointment availability during business hours from 8–5 pm and after hours on call access
Urgent appointments that do not require prior authorization	Within 48 hours of request
Urgent appointments that require prior authorization	Within 96 hours of request
Follow-up appointment for mental health care (non-physician) or substance use disorder providers for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition	10 business days from the prior appointment
Non-Urgent Care Services with a -NON-Physician Mental Health Provider	Within 10 business days of the request*
Urgent Care Services	Within 48-hours*
Follow-up appointment with non-physician mental health care substance use disorder Provider for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition	10 business days from the prior appointment *
Access to care for non-life-threatening Emergency Services	Within 6 hours
Access to follow-up care after hospitalization for mental illness	Must Provide Both: • One follow-up encounter with a mental health Provider within 7 calendar days after discharge, and • One follow-up encounter with a mental health Provider within 30 calendar days after discharge

Timely Access Standards - Cont.

Non-urgent substance use disorder opioid treatment (outpatient)	Within 3 business days
*Substance Use Disorder - Outpatient services	Within 10 business days
Telephone access after hours	• The phone message or live person must instruct members to dial 911 or go to the nearest emergency room. • The phone message or live person must provide instructions on how to contact or reach a physician for urgent care. • Triage or return call must be within 30 minutes of the call.
Telephone access after-hours and during business hours for emergencies	The phone message and/or live person must instruct members to dial 911 or go to the nearest emergency room
Routine preventative care services appointment	Within 30 business days of request
In-office wait time for scheduled appointments with a primary care provider (PCP)	Not to exceed 45 minutes
In-office wait time for scheduled appointments with a specialist	Not to exceed 60 minutes
Rescheduling appointments	Appointments will be promptly rescheduled in a manner appropriate to the member's health care needs and that ensures continuity of care consistent with good professional practice
Skilled Nursing Facility and Intermediate Care Facility	Within 7 business days of request (San Joaquin and Stanislaus Counties) Within 14 business days of request (El Dorado and Alpine Counties)

Provider Manual, Section 7 Provider- Member Relationship: - https://www.hpsj.com/wp-content/uploads/2025/11/2026-Medi-Cal-Provider-Manual-HPSJ-MVHP.pdf

*Note: Non-physician mental health providers include counseling professionals, substance abuse professionals, and qualified autism service providers.

Access Monitoring

Surveys to be conducted annually

1. Provider Appointment Availability
   - To monitor Providers' compliance with appointment availability per the Access and Availability standards. Monitoring to include follow-up actions for identified non-compliance.

2. After-Hours Access
   (Primary Care Providers)
   - The survey is designed to help determine the level of access our members have for urgent/emergent after-hours care with network providers.

   i. When a member calls after-hours, there should be instructions for the member to call 911 or go to the nearest emergency room if they are experiencing an emergency.

   ii. When a member calls after-hours, there should be a mechanism for members to reach a provider or receive a return call within 30 minutes to be triaged.

Access Monitoring - Cont.

3. In-Office Wait Time
   - Health Plans must monitor in-office wait times for scheduled appointments with a PCP and Specialist in their provider offices.

4. Call Answer and Return Time
   - The regulators require Health Plans to monitor call answer times during business hours and return call times.

5. Provider Satisfaction
   - Primary Care Providers, Specialists, and Behavioral Health providers will be surveyed annually to measure their satisfaction with Advantage D-SNP. Information obtained from this survey will allow Advantage D-SNP to measure expectations and needs. The data collected will assist in identifying Advantage D-SNP's strengths and opportunities.

Cultural and Linguistics Services

Language assistance is available at no cost to Advantage D-SNP members
It is vital to rely on ***qualified*** interpreter services (onsite, video, phone) when communicating with a member with limited English proficiency (LEP).

While family and friends often provide critical support to member health and wellbeing, relying on these parties, and particularly minors as interpreters, can compromise the accuracy of medical information. Encourage participation from friends and family in the member's care as appropriate but discourage reliance on these parties for interpreting.

Scheduled appointments
Contact Health Plan's Customer Service Department at 888.936.PLAN (7526); TTY/TDD 711 at least 5 business days prior to scheduled appointment to request a qualified, onsite, spoken language interpreter, or 10 business days for an onsite American Sign Language (ASL) interpreter.

It is required to document acceptance or refusal of language assistance in the member's medical record. (Form is located in DRE.)

Translation services
Translation of written member materials is also available to members at no cost.

Individuals with Disabilities
Advantage D-SNP shall provide Auxiliary aids and services to persons with impaired sensory, manual, or speaking skills including qualified interpreters and written materials in alternative formats (e.g. braille, large font) at no cost to members.

Mandatory Annual Provider Training

In compliance with state and federal regulations, Health Plan has established and implemented mandatory training. Advantage D-SNP network providers and their staff are required to complete the mandatory annual trainings and attest to having completed the trainings. Training and education are provided for all network providers and their staff. At least once a year, a Provider Alert is sent to all providers as a reminder to complete the required training.

If you have completed these trainings with another health plan, you must attest to completing the training through another source and provide proof of training. Proof can be a certificate of completion, training program outline, or web link to the training.

The following mandatory trainings are available on Advantage D-SNP's website at https://www.hpsj.com/provider-trainings/:

1. Anti-Fraud, Waste and Abuse
2. Cultural Competency and Sensitivity Training
3. Emergency Preparedness Training
4. Excellent Health Outcomes for All Training
5. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Training
6. Model of Care (MOC) Training

Anti-Fraud, Waste and Abuse Training

As a licensed health care services plan regulated by the Department of Managed Health Care (DMHC) and contracted with the Department of Health Care Services (DHCS), Advantage D-SNP is committed to protecting members, our network of providers, and public interests by preventing, detecting, investigating, correcting, and reporting Fraud, Waste, and Abuse (FWA).

Under legal requirements overseen by the federal Centers for Medicare & Medicaid Services (CMS), 42 C.F.R. §422.503 and 42 C.F.R. §423.504, providers and all employees are required to either complete the FWA training offered on the Advantage D-SNP's website or complete another, acceptable FWA training and upload a PDF version once completed. Only PDFs can be uploaded; please do not upload Word, Excel or other formats. After choosing one of the training options, providers must attest all employees completed the training by completing the attestation below.

Training Link: https://www.hpsj.com/fraud-waste-and-abuse-prevention-training/

Cultural Competency Training

As a licensed health care services plan, this training is mandated by California's Department of Health Care Services (DHCS) and the Federal Centers for Medicare and Medicaid Services (CMS) to ensure Network Providers and delegated entities are meeting the unique and diverse needs of all members. **As part of new federal requirements, Cultural Competency training will be noted in the Contracted Provider Directory.**

Under legal requirements, Title 22, California Code of Regulations (CCR) Sections, 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), 53910.5(a)(2); Title 28, CCR, Section 1300.67.04(c)(1)(A) through (B); and Title 42, Code of Federal Regulations (CFR), Sections 438.206(c)(2), 438.330(b)(4), 438.242(b)(2) **Health Plan is required to provide annual Cultural Competency training to our participating Contracted Provider network and delegated entities. Network Providers are required to either complete the training offered on Advantage D-SNP's website or through another health plan and submit a signed attestation.**

Training Link: https://www.hpsj.com/cultural-competency-training/

Cultural Competency

Cultural Competency Training covers

- What is Diversity?
- Why is Healthcare Diversity so important?
- Why is Cultural Diversity an Important Issue?
- What is Cultural Respect? Why is it Important?
- Cultural Differences; Cultural Competence
- Diversity includes LGBTQIA Members/Patients
- Cultural Competence Skills
- The Strengths of Cultural Competence and Diversity
- Cultural Competence Continuum
- Communication with Culturally Diverse Patients.

Persons with Disability (SPD) Awareness and Sensitivity

Persons with Disability (SPD) Awareness and Sensitivity training covers:

- Who are Seniors and Persons with Disabilities (SPDs)?
- What is Disability as defined by the Americans with Disability Act (ADA) and ADA Law
- Health Care Access issues for people with disabilities
- Types of disabilities and what SPDs need
- Best Practices

Training Link: https://www.hpsj.com/cultural-competency-training/

Emergency Preparedness Training

At Health Plan, we're committed to supporting you, our valued Network Partners, in delivering exceptional care to our members. We understand that emergencies can impact your ability to provide healthcare, and we're here to work together with you to ensure the safety, well-being, and continuity of care for everyone involved.

Advantage D-SNP aims to create a seamless and collaborative approach to **Emergency Preparedness**, ensuring we're all ready to respond effectively when it matters most.

Training Link: https://www.hpsj.com/emergency-preparedness-training/

Excellent Health Outcomes for All Training

Health Plan is required by the California Department of Health Care Services (DHCS) to ensure that all network providers/subcontractors, downstream subcontractors, complete Diversity, Equity, and Inclusion (DEI) training (Excellent Health Outcomes for All), per All Plan Letter (APL) 24-016.

The training includes content on sensitivity, diversity, cultural competency and humility, and health equity. New providers must complete the training within 90 days of hiring or contracting. All providers are required to complete training again at re-credentialing or contract renewal.

Training may be completed using the materials available on our website or by completing equivalent training from another Managed Care Plan and providing proof of completion. After completing the training, network providers must attest on behalf of themselves and any applicable personnel who have completed the training below.

Training Link: https://www.hpsj.com/excellent-health-outcomes-for-all-training/

HIPAA Provider Training

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law requiring national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The US Department of Health and Human Services (HHS) issued the HIPAA Privacy Rule to implement the requirements of HIPAA. The HIPAA Security Rule protects a subset of information covered by the Privacy Rule.

HIPAA Privacy Rule
The Privacy Rule standards address the use and disclosure of individuals' health information (known as "protected health information") by entities subject to the Privacy Rule. These individuals and organizations are called "covered entities." The Privacy Rule also contains standards for individuals' rights to understand and control how their health information is used. A major goal of the Privacy Rule is to ensure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high-quality health care and to protect the public's health and well-being. The Privacy Rule strikes a balance that permits important uses of information while protecting the privacy of people who seek care and healing.

Training Link: https://www.hpsj.com/hipaa-training/

Model of Care (MOC) Training

As a licensed plan for Centers for Medicare & Medicaid Services (CMS), Health Plan must ensure that all network providers and applicable personnel complete annual training on the Special Needs Plan (SNP) Model of Care.

This requirement applies to network providers providing health care services to Dual Eligible Special Needs Plan (D-SNP) members or who administer D-SNP health care benefits. The provider training material is updated annually to reflect any changes to the program's regulatory requirements.

Training may be completed using the MOC materials available on our website or by completing an equivalent MOC training and providing proof of completion. After completing the training, network providers must attest on behalf of themselves and any applicable personnel who completed the training by completing the attestation below.

Training Link: https://www.hpsj.com/model-of-care-training/

Health Plan of San Joaquin

Mountain Valley Health Plan

MEDICAL MANAGEMENT

HPSJ Standards for Quality Care

Our standards serve as the foundation for accountability and help ensure that our members consistently receive high-quality health care. They also guide us in meeting the expectations established by government regulators and national accreditation organizations, such as the National Committee for Quality Assurance (NCQA).

We value our partnership with our contracted network providers and rely on your commitment to these shared standards. Together, we can continue to deliver exceptional, patient-centered care and achieve the highest levels of performance for the communities we serve.

Since 2015, HPSJ has consistently earned NCQA accreditation through comprehensive reviews of our quality initiatives and service delivery processes. We are proud to stand among one of the 26 Medi-Cal Plans in California that have achieved this distinction.

This recognition reflects not only HPSJ's commitment to quality, but also the shared dedication of our provider partners. NCQA surveys Health Plans every three years to ensure that, together, we continue to uphold the highest standards of care to the communities we serve.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). It is used by more than 90% of health plans nationally to evaluate performance across key areas of care, such as preventative services, chronic disease management and patient experience.

The Health Plan reports over 70 of these measures each year to the Department of Health Care Services (DHCS), The Department of Managed Care (DMHC), The Centers for Medicare & Medicaid (CMS) and The NCQA. This reporting includes the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results and the Health Outcomes Survey (HOS).

The HP is committed to partnering with our providers to not just achieve but surpass regulatory goals including:

- Achieving and exceeding the NCQA national 50th percentile or DHCS Minimum Performance Level (MPL) for all required measures
- Attaining at least a 4 Star rating for NCQA's Health Plan Ratings
- Attaining at least a 4 Star rating for CMS' Medicare Stars Program

For more information about Health Plan's HEDIS process, please contact Health Plan's HEDIS team at HEDIS@hpsj.com

HEDIS - Continued

Your Role in HEDIS:

You are a key part of our members' care. With your support, we can reach members early, close gaps, and make sure their health needs are always a priority.

Key Actions That Support HEDIS Success:

- ❑ Use care gap reports to identify and outreach to members to schedule their next visit
- ❑ Complete Preventive Care – Initial Health Appointments, Annual Wellness Visits, Well-Child Visits, Immunizations and all recommended screenings.
- ❑ Provide disease management education and assistance in maintaining compliance with treatment plans.
- ❑ Document all services clearly and accurately in medical records.
- ❑ Timely submission of claims and/or encounters with appropriate codes.
- ❑ Active participation with Advantage D-SNP in programs & initiatives.
- ❑ Ensure continuity of care by coordinating and collaborating with other providers.
- ❑ Work proactively to close care gaps by reaching out to members who are overdue for care.

HEDIS, Stars, Health Equity and Quality Measure Set (HEQMS)

Measure	Definition	DHCS MCAS 2026	NCQA HPR	Medicare Stars	DMHC HEQMS
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis - Total		X		
AAF	Follow-up after Acute and Urgent Care Visits for Asthma	X			
ADD-E-C&M	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase		X		
AIS-E-FLU	Adult Immunization Status-Influenza		X	X	
AIS-E-Pneumo-66+	Adult Immunization Status-Pneumo-66+		X		
AIS-E-Td/Tdap	Adult Immunization Status-Td/Tdap		X		
AIS-E-Zoster	Adult Immunization Status-Zoster		X		
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics		X		
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		X		
BCS-E	Breast Cancer Screening	X	X	X	X
BPD	Blood Pressure Control for Patients with Diabetes		X		
CAHPS	CAHPS-Getting Needed Care Composite-Adult			X	X
CAHPS	CAHPS-Getting Care Quickly Composite-Adult			X	
CAHPS	CAHPS-Customer Service Composite			X	
CAHPS	CAHPS-Getting Needed Care Composite-Child				X
CAHPS	CAHPS-Getting Care Quickly Composite-Child				
CBP	Controlling High Blood Pressure	X	X	X	X
CCS-E	Cervical Cancer Screening	X	X		
CHL	Chlamydia Screening		X		
CIS-10-E	Childhood Immunization Status - Combo 10	X	X		X
COA-Med	Care of Older Adults - Medication Review			X	
COA-Pain	Care of Older Adults - Pain Screening			X	
COL-E	Colorectal Cancer Screening	X	X	X	X
DEV-CH	Development Screening in the First Three Years of Life	X			
DRR	Depression Remission or Response for Adolescents and Adults				
DSF-E-DS	Depression Screening and follow-up for Adolescents & Adults-Screening	X			X
DSF-E-FU	Depression Screening and follow-up for Adolescents & Adults-Follow-Up	X			X
EED	Eye Exam for Patients With Diabetes		X	X	

For additional information , please ref to http://www.ncqa.org/hedis-quality-measurement

HEDIS, Stars, HEQMS Measures – Cont.

Measure	Definition	DHCS MCAS 2026	NCQA HPR	Medicare Stars	DMHC HEQMS
FMC	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions			X	
FMC	Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions			X	
FUA-30	Follow-Up After ED Visit for Substance use, 30-Day	X		X	
FUA-7	Follow-Up After ED Visit for Substance use, 7-Day		X		
FUH-7 DAYS	Follow-Up After Hospitalization for Mental Illness-7 days		X		
FUI-7DAYS	Follow-Up After High-Intensity Care for Substance Use Disorder-7 days		X		
FUM-30	Follow-Up After ED Visit for Mental Illness, 30-Day	X			
FUM-7	Follow-Up After Hospitalization for Mental Illness, 7-Day		X		
GSD-8	Glycemic Status Assessment for Patients With Diabetes – <8% (GSD-8)		X	X	X
GSD-9	Glycemic Status Assessment for Patients With Diabetes – >9% (GSD-9)	X		X	X
HOS-FRM	Fall Risk Management			X	
HOS-MUI	Improving Bladder Control: Management of Urinary Incentenance			X	
HOS-PAO	Monitoring Physical Activity: Physical Activity in Older Adults			X	
IET-SUD	Initiation and Engagement of Substance Use Disorder Treatment-Engagement of SUD Treatment Total		X		
IMA-2-E	Immunizations for Adolescents - Combo 2	X	X		X
KED	Kidney Health Evaluation for Patients with Diabetes-Total		X	X	
LSC-E	Lead Screening in Children	X			
MRP	Medication Reconciliation Post-Discharge			X	
OMW	OstOsteoporosis Management in Women with Fracture			X	
PCR	Plan All-Cause Readmissions		X	X	X
PDE-MAH	Medication Adherence for Hypertension (RAS antagonists)			X	
PDS-E FU	Postpartum Depression Screening and Follow-Up - Follow-Up	X			
PDS-E-DS	Postpartum Depression Screening and Follow-Up - Depression Screening	X			
PND-E FU	Prenatal Depression Screening and Follow-Up - Follow-Up	X			
PND-E-DS	Prenatal Depression Screening and Follow-Up - Depression Screening	X			
POD	Pharmacotherapy for Opioid Use Disorder		X		
PPC-Post	Prenatal and Postpartum Care - Postpartum Care	X	X		X
PPC-Pre	Prenatal and Postpartum Care - Timeliness of Prenatal Care	X	X		X
PRS-E	Prenatal Immunization Status- Combo		X		

For additional information , please ref to http://www.ncqa.org/hedis-quality-measurement

HEDIS, Stars, HEQMS Measures – Cont.

Measure	Definition	DHCS MCAS 2026	NCQA HPR	Medicare Stars	DMHC HEQMS
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia		X		
SPC-80%	Statin Therapy for Patients with Cardiovascular Disease-Statin Adherence 80%		X	X	
SPC-Recvd	Statin Therapy for Patients with Cardiovascular Disease-Received Statin Therapy		X		
SPD-80%	Statin Therapy for Patients with Diabetes - Statin Adherence 80%		X		
SPD-Recvd	Statin Therapy for Patients with Diabetes - Received Statin Therapy		X	X	
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		X		
TFL-CH	Topical Fluoride for Children	X			
TRC	Transistions of Care			X	
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 months - Two or More Well-Child Visits	X	X		X
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months - Six or More Well-Child Visits	X	X		X
WCC-BMI	Weight Assessment for Children/Adolescents - BMI ONLY		X		
WCV	Child and Adolescent Well-Care Visits	X	X		X

For additional information , please ref to http://www.ncqa.org/hedis-quality-measurement

Clinical Guidelines & CDC Immunization Schedule

At Advantage D-SNP, the vigor of our healthcare programming rests on a strong partnership with our Network Providers, practitioners, and their staff. As part of our alliance, we offer education and training tools to help Network Providers connect with our members. Health Plan strives to help Network Providers achieve best practice status. We believe excellence is attainable. To that end, Advantage D-SNP offers tools to assist our Network Providers in meeting and maintaining proven best practices, beginning with Clinical Practice Guidelines.

Clinical Practice Guidelines are guidelines about a defined task or function in clinical practice, such as desirable diagnostic tests or the optimal treatment regimen for a specific diagnosis. They are generally based on the best available clinical evidence. In addition to Clinical Practice Guidelines, we also offer Preventive Health Guidelines for Children and Adults.

Follow the links on the next slide to access Current Year Clinical Practice Guidelines and the Center of Disease Control and Prevention (CDC) Immunization Schedules for children and adults.

Clinical Guidelines & CDC Immunization Schedule

Clinical Guidelines:
https://www.hpsj.com/clinical-practice-guidelines/

- ✓ Adult Immunization Schedule by Vaccine and Age Group
- ✓ Adult Immunization Schedule by Medical and Other Indications

Health Plan of San Joaquin

Mountain Valley Health Plan

UTILIZATION MANAGEMENT

Utilization Management-Prior Authorizations (PA)

Providers should always first verify the Member's eligibility through Doctor's Referral Express (DRE) before submitting a referral for Authorization for Covered Services. Information on other methods to verify a Member's eligibility is detailed in this slide deck under "Eligibility Verification, Member Enrollment." The Authorization Request Form is available online in DRE or can be submitted by fax.

Prior Authorization Form can be printed or downloaded at: HPSJ-MVHP_PRIOR-AUTHORIZATION-FORM_06032024E_FILLABLE-1.pdf

To ensure prompt response to Authorizations, **it is preferable to submit the Authorization online through, DRE.** By submitting referrals online, Providers have immediate access to the status of the referral. Authorization status is not immediate or may be delayed when the referral is faxed. Providers can communicate directly with Health Plan staff via DRE regarding any aspect of the Authorization status.

- Providers should always refer to the "search code" in DRE to identify if a service requires prior authorization

You can also reference the Medi-Cal or CMS website to validate if services are a covered benefit.

CMS website - Medicare
https://www.cms.gov/

Medi-Cal website
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references

Utilization Management – PA (Cont.)

Advantage D-SNP's mission is to improve the health of our community continuously. Health Plan supports its mission through our vision statement to provide health care value and advance wellness.

Our affirmation statement about Utilization Management Incentives is clearly understood by all Advantage D-SNP staff involved in UM decision-making as follows:

- UM decision making is based only on appropriateness of care and services and existence of coverage.
- Health Plan does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

For further education on Utilization Management and Prior Authorizations, refer to the Provider Manual, Section 8. https://www.hpsj.com/provider-manual/

Decisions and Notifications

Decisions and notifications must be made to providers and members within:

- Expedited or Urgent Requests 72 hours of receipt of request
  - Considered received when delivered to the appropriate department
  - May be downgraded to standard if they do not meet the definition of expedited; The members life or health or the ability to regaining maximum services must be in jeopardy.
  - If deny request for expedited determination (downgrade), the request must be transferred to standard initial determination process
  - Provide notice to provider and member of the downgrade
- Standard requests are 7 calendar days from receipt of request

Notice of Medicare Non-Coverage (NOMNC)

- Must be delivered to D-SNP members when their coverage is ending
- Specific to Home Health, Skilled Nursing and Comprehensive outpatient rehab
- Must be given at least 2 days prior to last day of service
  - May need to be given week before for Home Health if member is not getting daily visits
- Must be returned to Advantage D-SNP once signed by the D-SNP member
- Member may request an expedited appeal

Facility Care Limits

Skilled Nursing Care: 100 days per benefit period

- LTC is covered under the Medi-Cal benefit
- If member is not in a facility for 60-days after exhausting benefit, it will automatically renew for another 100 days

Free Standing Psychiatric Hospital; 190 days lifetime maximum

- Does not apply to a Psychiatric unit at an acute care hospital

Health Plan of San Joaquin

Mountain Valley Health Plan

CASE MANAGEMENT

Referral Form

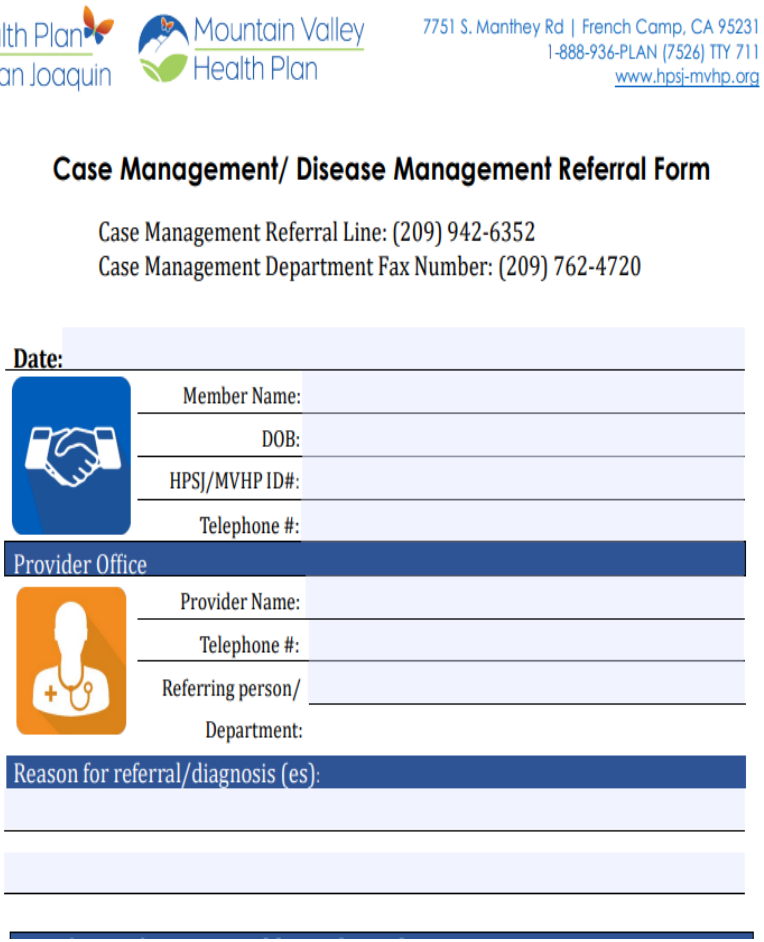
Refer patients to Disease Management, Complex Case Management & Care Management Services:

1. Fax referral form
    a. Download the referral form at: https://www.hpsj.com/forms-documents/

    b. Fax form to 209.762.4720

2. Call us and leave a message at: Case Management Referral Line: 209.942.6352

3. Referral can be sent online on DRE/Provider Portal



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7751 S. Manthey Rd | French Camp, CA 95231
1-888-936-PLAN (7526) TTY 711
www.hpsj-mvhp.org

Case Management/ Disease Management Referral Form

Case Management Referral Line: (209) 942-6352
Case Management Department Fax Number: (209) 762-4720

Date:

Member Name:
DOB:
HPSJ/MVHP ID#:
Telephone #:

Provider Office

Provider Name:
Telephone #:
Referring person/ Department:

Reason for referral/diagnosis (es):

Case/Disease Management

Asthma, Diabetes, COPD, CHF, Chronic Kidney Disease

Disease Management is the process in which we assess, plan, implement, coordinate, monitor and evaluate options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes.

Call Case Management at 209-942-6352
to refer a member
Members and caregivers can self-refer

Health Plan of San Joaquin

Mountain Valley Health Plan

HEALTH EDUCATION

Health Education Services

Health Education Materials

- Available for download by clicking categories at www.hpsj.com/health-education-programs/
- Websites and online resources
- **Request materials by emailing** healtheducation@hpsj.com

Member Engagement

- Community Advisory Committee
- https://www.hpsj.com/cac/

FOCUS Member Newsletters

- Quarterly newsletter featuring seasonal and relevant health education to all member homes
- https://www.hpsj.com/focus-your-health-newsletter/

Community Advisory Committee

What is the Community Advisory Committee?

The Community Advisory Committee (CAC) is a state-mandated meeting that allows our members to improve health care for their family, friends and neighbors. The health education team facilitates and coordinates this meeting. Join now!

What is the purpose of the CAC meetings?

CAC meetings will be virtual or in person. The CAC is designed for our member. They will have a chance to share their ideas, create programs and help us better serve our members. Their ideas can make a difference!

The CAC creates a space for our members to be heard, share their ideas and earn a $40 stipend for each meeting they attend. Interpretation services available upon request.

Join us to share your ideas and earn a $40 stipend!

Share your ideas and help improve health in our community. Join the **Community Advisory Committee** (CAC) today!

We want you!

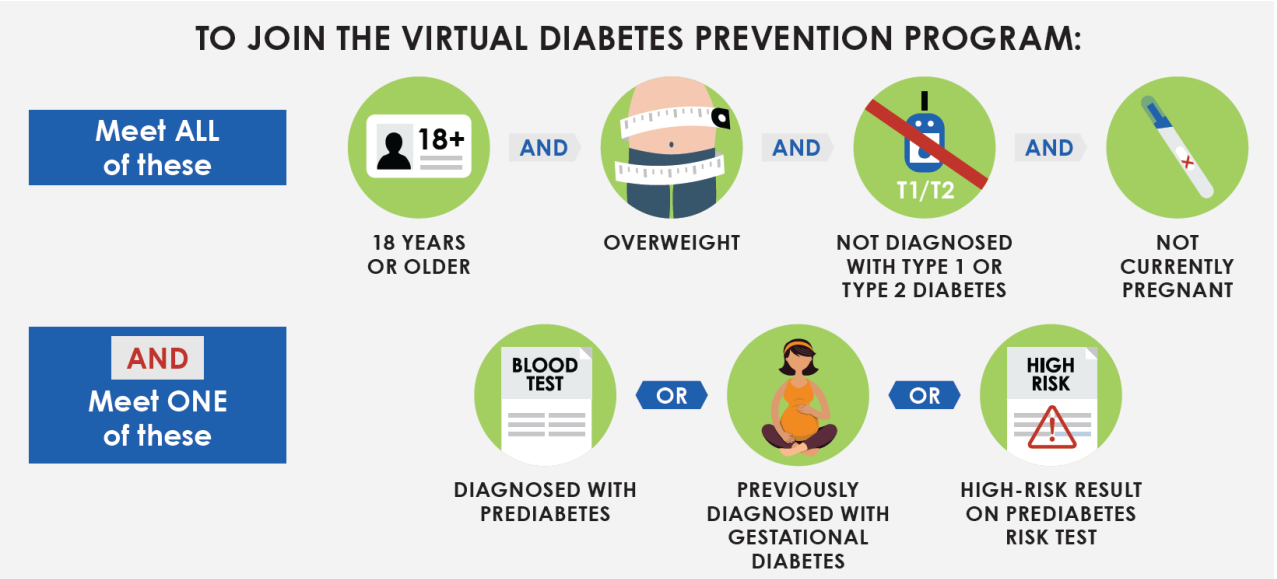
Join Now!

Diabetes Prevention Program (DPP)

The Diabetes Prevention Program (DPP) is a CDC recognized; evidence based preventive health program aimed at improving health outcomes in those at risk of developing Type II diabetes.
Participants who complete the program have benefited from:

- ✓ An average of **5-7% weight loss** after one year.
- ✓ Maintaining a routine of 150 minutes of exercise per week.
- ✓ Lowering risk of developing type 2 diabetes by up to 58%.

Sign up at Workshops – Inspiring Communities Inspiringcommunities.org/workshops



*DPP is **NOT** for those who have Type 1 or Type 2 diabetes or are pregnant at this time.*

Scan with your smart phone

in partnership with

Inspiring Communities

Health Plan of San Joaquin

Mountain Valley Health Plan

PHARMACY BENEFITS

Understanding Medicare Drug Coverage Part A and Part B

- Medical Drug Benefit
  - Covers medications administered in a **clinical setting**, such as a hospital, provider's office, or outpatient clinic.
  - These medications are **typically administered by the provider** during treatment.
  - **Examples:** chemotherapy, injectable medications, or infusion therapies.
  - Learn more at https://www.hpsj.com/d-snp-member-materials/

For a complete list of covered benefits, limitations and exclusions, refer to Advantage D-SNP Evidence of Coverage/Member Handbook. https://www.hpsj.com/d-snp-member-materials/

For a complete list of covered drugs, refer to Advantage D-SNP Drug Formulary (https://www.hpsj.com/d-snp-member-materials/)

Understanding Medicare Drug Coverage Part D

- Pharmacy Drug Benefit
- Managed through MedImpact, the Pharmacy Benefit Manager (PBM)
- Benefit Structure is a 6-tier formulary
- Prescriptions filled at network pharmacies or through Mail-Order
- D-SNP Enrollees get Extra Help/Low-Income Subsidy (LIS) from Medicare to pay for Part D Drugs. This program covers or reduces premiums, deductibles and copays
- Learn more at https://www.hpsj.com/d-snp-pharmacy-drug-benefits/

MedImpact Resources for Providers:

- **Provider Portal:** https://www.medimpact.com/web/login
- **Customer Service:** 1-833-546-0796
  - Available 24 hours a day, 7 days a week, 365 days per year

Member Cost-Sharing for Part D Covered Drugs

Tier	Subject to the Deductible	Coinsurance	Low-Income-Subsidy Copays	Max Day Supply
Tier 1 (Preferred Generic)	No	0%	$0.00	100
Tier 2 (Generic)	Yes	25%	$1.60 - $4.90	90
Tier 3 (Preferred Brand)	Yes	25%	$5.10 - $12.65	90
Tier 4 (Non-Preferred Brand)	Yes	25%	$1.60 - $12.65	90
Tier 5 (Specialty)	Yes	25%	$1.60 - $12.65	30
Tier 6 (Select Care Drugs)	No	0%	$0.00	100

How Members Access Their Part D Prescription Drugs

Members can fill their covered Part D prescriptions at:

- **Local pharmacies**
- **Mail-order pharmacy** (accessible through the member portal; medications delivered to the member's home)
- Specialty Pharmacies
- Members should present both their **Medicare card** and their **Advantage D-SNP member ID card** when filling prescriptions.

If members need assistance, such as help with medications, copays, drug limitations, or locating a network pharmacy, they may contact **Customer Service** for support.

Health Plan of San Joaquin

Mountain Valley Health Plan

MENTAL HEALTH, SUBSTANCE USE DISORDER, AND BEHAVIORAL HEALTH TREATMENT

D-SNP- Mental Health and Substance Use Disorder

Behavioral health coverage through the health plan is managed by Advantage D-SNP and is available to members in San Joaquin, Stanislaus, El Dorado and Alpine counties. Please review the grid below to make the appropriate referrals.

Referral	Action(s)
Outpatient (OP) treatment for mental health conditions: • Individual, family and group mental health • Psychological testing to evaluate a mental health condition • Lab work, drugs and supplies • Drug therapy monitoring	Outpatient services do not require prior authorization, with the exception of Transcranial Magnetic Stimulation (TMS). If a member requires or could benefit from care coordination or care management: (proceed with actions already there) Call Health Plan at **1-888-361-7526** Complete and submit to Health Plan the Behavioral Health Services Referral Form for care coordination or case management. Email: BHCM@hpsj.com
Intensive Outpatient Program (IOP)	Prior Authorization is required. Provider needs to submit a request. Forms & Documents for HPSJ/MVHP Providers Under "Prior Authorizations" – use the DSNP form for BH
Partial Hospitalization Program (PHP)	
Inpatient Psychiatry Hospital (IP)	

For more information go to: https://www.hpsj.com/providers/behavioral-health-services/ or D-SNP Member Handbook at https://www.hpsj.com/d-snp-member-materials/

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INTEGRATED CARE & SUPPORTS

California Integrated Care Mgmt. (CICM)

CICM is the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. The goal of CICM program is to ensure delivery of extra medical and behavioral interventions, services and benefits that meet the specialized needs of these most vulnerable beneficiaries as evidenced by measures from psychosocial, functional, and end-of-life domains. Advantage D-SNP relies heavily on Provider partnerships to meet these complex needs.

Key features of this program are:

- Clearly identify the target populations
- Enhance care coordination between all Providers
- Integrate all services to help reduce fragmentation, improving overall quality of care
- Reduce health disparities by providing more comprehensive care to those who often face barriers
- Involve ICT to guide individuals to receive appropriate services

CICM Populations

Advantage D-SNP is committed to strong collaboration with providers to deliver the highest quality care possible for these eight most vulnerable subpopulations, as defined by the State of California:

- Adults experiencing homelessness
- Adults with serious mental health or substance use disorder needs
- Adults transitioning from incarceration
- Adults at risk for avoidable hospital or emergency room (ER) utilization
- Adults with documented dementia needs
- Adults pregnant or postpartum and subject to racial and ethnic disparities
- Adult nursing facility residents transitioning to the community
- Adults living in the community at-risk for long-term care institutionalization

CICM Identification and Interventions

CICM Members are specifically identified for the Case Management Department and stratified into the CCM program for intense intervention. Health Plan seeks to actively engage PCPs, specialists and community-based organizations in the development, implementation and evaluation of the ICP.

Community Support Services

Community Support Services (CSS) are optional, no cost services available to members. These services can help members live more independently and have a better quality of life.

Community Supports are alternative services to those covered under the Medi-Cal State Plan. They do not replace benefits that members already get under Medi-Cal.

Community Supports Offered

	**Transitional Rent** Covers up to six months of rent for members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria. Transitional Rent is designed to provide a time-limited opportunity to help a member exit homelessness, or no longer be at risk of entering into homelessness, and establish a bridge to permanent housing.
	**Housing Transition Navigation Services** Members experiencing homelessness or at risk of experiencing homelessness receive help to find, apply for, and secure housing.
	**Housing Deposits** Members receive assistance with housing security deposits, utilities set-up fees, first and last month's rent, and first month of utilities. Members can also receive funding for medically necessary items like air conditioners, heaters, and hospital beds to ensure their new home is safe for move-in.
	**Housing Tenancy and Sustaining Services** Members receive support to maintain safe and stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.
	Members who do not have a residence, and who have high medical or mental health and substance use disorder needs, receive short-term housing for up to six months to continue their recovery. To receive this support, members must also have been discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.
	**Recuperative Care (Medical Respite)** Members with unstable housing who no longer require hospitalization, but still need to heal from an injury or illness, receive short-term residential care. The residential care includes housing, meals, ongoing monitoring of the member's condition, and other services like coordination of transportation to appointments.

Community Supports Offered - Cont.

	**Respite Services** This provides short-term relief for member caregivers. Members may receive caregiver services in their home or in an approved facility on an hourly, daily, or nightly basis as needed.
	**Day Habilitation Programs** Members who are experiencing homelessness, are at risk of experiencing homelessness, or formerly experienced homelessness, receive mentoring by a trained caregiver on the self-help, social, and adaptive skills needed to live successfully in the community. These skills include the use of public transportation, cooking, cleaning, managing personal finances, dealing with and responding appropriately to governmental agencies and personnel, and developing and maintaining interpersonal relationships. This support can be provided in a member's home or in an out-of-home, non-facility setting.
	**Nursing Facility Transition/Diversion to Assisted Living Facilities** Members living at home or in a nursing facility are transferred to an assisted living facility to live in their community and avoid institutionalization in a nursing facility, when possible. Assisted living facilities provide services to establish a community facility residence, such as support with daily living activities, medication oversight, and 24-hour onsite direct care staff.
	**Community Transition Services/Nursing Facility Transition to a Home** Members transitioning from a nursing facility to a private residence where they will be responsible for their own expenses, receive funding for set-up services, such as security deposits, set-up fees for utilities, and health-related appliances, such as air conditioners, heaters, or hospital beds.
	**Personal Care and Homemaker Services** Members who require assistance with Activities of Daily Living or Instrumental Activities of Daily Living receive in-home support, such as bathing or feeding, meal preparation, grocery shopping, and accompaniment to medical appointments.

Community Supports Offered – Cont.

	**Environmental Accessibility Adaptations (Home Modifications)** Members receive physical modifications to their home to ensure their health and safety and allow them to function with greater independence. Home modifications can include ramps and grab-bars, doorway widening for members who use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.
	**Medically-Supportive Food/Medically Tailored Meals** Members receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.
	**Sobering Centers** Members who are found to be publicly intoxicated are provided with a short-term, safe, supportive environment in which to become sober. Sobering centers provide services such as medical triage, a temporary bed, meals, substance use education and counseling, and linkage to other health care services.
	**Asthma Remediation** Members receive physical modifications to their homes to avoid acute asthma episodes caused by environmental triggers like mold. Modifications can include filtered vacuums, dehumidifiers, air filters, and ventilation improvements.

***Note:** El Dorado and Alpine Counties do not have Sobering Centers.

More Information on CalAIM

Health Plan Website - https://www.hpsj.com/providers/calaim-2/

DHCS Resources and Policy Guide - https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

CICM and CSS

- CICM works with community support providers to help coordinate members needs.
- CSS providers are encouraged to obtain access to Doctor's Referral Express (DRE) portal for eligibility verification and to facilitate prior authorization submission.
- For any community support prior authorizations, providers should follow Advantage D-SNP's prior authorization process.
- Duration of authorizations depends on the type/service of request.
- Community Support referrals may come from multiple sources. Referring providers will submit a referral directly to the CSS provider for the respective community support being referred to. The CSS provider will submit a prior authorization request to Health Plan. If the member meets the criteria and is approved, a prior authorization will be created per Advantage D-SNP's standard prior authorization process.

  For a list of CSS providers and contact information, visit Health Plan's website at https://www.hpsj.com/providers/calaim-2/

Health Plan of San Joaquin

Mountain Valley Health Plan

GRIEVANCE AND APPEALS

Identify a Grievance

WHAT IS A GRIEVANCE?

Any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of a plan, provider, or facility *regardless of whether remedial action is requested*.

WHEN CAN A GRIEVANCE BE SUBMITTED?

A grievance may be filed at any time.

WHO CAN SUBMIT A GRIEVANCE?

The member, member's representative or a provider the member designates as their representative.

HOW CAN A GRIEVANCE BE SUBMITTED?

A grievance may be submitted verbally or in writing.

Grievance Examples

- Problems getting an appointment, or having to wait a long time for an appointment
- Disrespectful or rude behavior by doctors, nurses or other plan clinic or hospital staff
- Member feels they are being discharged from a facility too soon
- Member is being billed for covered services or services they did not receive
- Member is experiencing delays in receiving services such as DME or supplies

Document the grievance

- Provider name, representative name receiving the grievance from the enrollee/authorized representative.
- How the member filed the grievance --- verbal or in writing.
- Member name and id number or authorized representative name and contact phone number and address.
- Confirm member contact information is accurate and if not, document current contact info
- Date and time of call or face-to-face interaction or written grievance received
- When incident occurred – Date and time
- Where incident occurred – doctor's office, lab, call to plan, etc.
- Who was involved – provider/staff names, representative, contact information if available
- What happened – Narrative description of the grievance as stated by the member or authorized representative

Respond to the member

Empathize – 'I see you are frustrated.'

Confirm understanding –'Let's make sure I have all the details.' Repeat issue to ensure accuracy and document.

Inform member - 'I will share your concern with the Health Plan who will investigate and provide a response to you. Please be aware they may call you to obtain more details and notify you of the outcome. Would you prefer the plan respond to you in writing? You may also contact the Health Plan directly at the Customer Service number on the back of your card or by mail (provide address).'

NOTE: Send the grievance to the Health Plan even if the member indicates they do not need a response.

Forward to Advantage D-SNP- Send to Grievance & Appeals Department on the same day provider receives the grievance.

Transmit the grievance to Health Plan Grievance & Appeals Department

Grievances must be sent to Advantage D-SNP the same day they are received to ensure regulatory timeframes are met.

Member or Provider may submit grievances by:

Method	Part C (including Part B drugs) and Part D
Secure Email	Grievances@hpsj.com
Fax	1-209-942-6355
Phone	1-888-361-PLAN (7526) or TTY 711
Online	https://www.hpsj.com
Mail (for enrollees only)*	Health Plan of San Joaquin 7751 South Manthey French Camp, CA 95231-9802

****Due to timeframe requirements providers may not mail grievances to the Health Plan***

Understand the grievance process at Advantage D-SNP

Categorize grievances as expedited or standard –

A grievance may be expedited only when:

- It is related to a decision not to grant a member's request to expedite an initial determination or appeal, and
- Part D only - the member has not yet obtained the drug

Resolution timeframe is based on categorization and as expeditiously as the case requires, based on the member's heath status, but no later than:

Expedited - 24 hours

Standard - 30 calendar days

Understand the grievance process at Health Plan – Cont.

Acknowledge receipt of grievance with member

Investigate details of case

- May contact member for additional context, information
- Outreach to provider, vendor, or FDR by Request for Response letter
    - Includes a summary of the grievance
    - Asks probing questions for additional detail
    - Requests response by a date specified
    - Identifies how to return responses – fax or email
- Outreach to internal departments as needed to obtain additional information.
- Complete investigation phase

Prepare and document resolution

Deliver resolution based on submission method (verbal or written) or written if requested by member.

Understand the provider responsibilities for responding to a grievance

Receive and promptly review request for response letter

- Provide a summary of your understanding of the situation and add context:
  - Who provided information to the enrollee in this situation?
  - What information was shared with enrollee by provider?
  - What alternatives if any were offered?
  - What was the outcome of the situation from your point of view?
- Respond to detailed questions included in the request for response letter.
- Include any attachments which may help clarify the situation or resolve the issue for member.
- Return response within the requested timeframe.

NOTE: The Grievance & Appeals staff may outreach to provider via phone for expedited grievances.

Quick Reference

GRIEVANCES – Send to HPSJ/MVHP same day received by Provider					
Category	**Request type**	**Who can request**	**Submission method**	**Resolution Timeframe**	**Response method**
Expedited	Part C (includes Part B drugs) &Part D	Enrollee, Enrollee's authorized representative, provider on behalf of enrollee	Verbal or written	24 hours	Verbal and written if submitted in writing or requested by member
Standard				30 calendar days	Same as submission method or in writing if requested by member

Training Objectives - Appeals (Reconsiderations)

- Properly identify
  - Provider Dispute
  - Appeal
  - Organization determination
  - Coverage determination
- Prepare provider appeal
- Redirect member appeal
- Transmit appeals to responsible party
- Understand Health Plan appeals process
- Understand provider responsibilities in appeals process

Identify Provider Dispute vs. Appeal

Contracted Provider: All requests for reconsideration of any type are addressed through the Provider Dispute Resolution Process and must be submitted through the Provider Portal/Doctors Referral Express (DRE) <provider.hpsj.com/dre/default.aspx>.

The following appeal process applies to members/members' representative and non-contracted providers.

Non-Contracted Provider: Requests for reconsideration of the amount a provider would have been entitled to under original Medicare are addressed through the Provider Dispute Resolution Process. All other requests for reconsideration are categorized as an appeal.

Non-contracted providers must mail provider disputes with the appropriate Health Plan Provider Dispute Resolution form to the attention of the claims department at:

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP
P.O. Box 30490
Stockton, CA. 95213-30490

Identify an Appeal (Reconsideration)

WHAT IS AN APPEAL?

A request to reconsider a previous plan decision to deny, reduce or partially approve a service or payment request. An appeal may occur only after an organization determination, coverage determination, notice of discharge from an inpatient facility, or reduction in service from skilled nursing or a rehabilitation facility has been issued by the Health Plan.

A reconsideration is the first level of appeal.

WHEN MAY AN APPEAL BE SUBMITTED?

A reconsideration must be filed within **65 calendar days** from the date of the notice of the initial determination unless Good Cause can be established.

Good Cause may include:

- Member did not receive notice or received notice late
- Member was seriously ill
- An accident resulting in destruction of records

WHO CAN SUBMIT AN APPEAL?

A member, member's authorized representative, or non-contracted provider.

HOW CAN AN APPEAL BE SUBMITTED?

An appeal may be submitted verbally or in writing.

Appeals examples

From a member:

- *"My doctor said I need this service and you denied it. I want it approved."*
- *"I asked for 10 physical therapy visits and HPSJ only approved 6. I need at least 12."*
- *"HPSJ denied my reimbursement request. I need that money asap."*
- *"The doctor is billing me for <services>. HPSJ should be paying this. I need HPSJ to pay this provider."*
- *"I was told I'm being discharged from the hospital. I need more time to recover."*

From a provider:

- *"The Health Plan denied the prior authorization request using the wrong criteria and need to evaluate based on this evidence."*
- *"The Health Plan took a 50% reduction in error. I need to be paid for the full amount."*
- *"The PBM incorrectly denied the medication request indicating other drugs, which have already failed, should be tried first."*
- *"The patient needs additional days in rehab to regain function."*

Provider Appeals - Prepare the request

- Name of provider and primary contact name, role, phone number and address of individual submitting appeal
- Completed Waiver of Liability(WOL) for non-contracted providers only. Available at https://www.hpsj.com/
    - *NOTE: Requests received without the WOL will be dismissed if not received in the required timeframes.*
- Prior authorization number, claim number, or notice indicating the partially favorable, denial, or reduction in services for which reconsideration is requested.
- If prior authorization or claim number is not available, describe the dates and provider of service, procedure, medication, diagnosis, or stay to be reconsidered
- Member name and id number or authorized representative name and contact phone number and address.
- Describe the desired outcome – Fully approved, extended stay, more visits, paid by Health Plan, etc.
- Attach any relevant evidence supporting the request for reconsideration – medical records, lab results, pricing results, Medicare fee schedule amount or pricing calculation, etc.
- If appealing a pre-service or concurrent service: is this a matter of urgency, i.e. expedited?
    - *NOTE: Provider payment reconsiderations are categorized as standard.*

Member Appeals - Redirect the member

Empathize

'I understand you want the Health Plan to reconsider the decision to deny or reduce the <service, procedure, drug>.

Inform member

'To request a reconsideration, you will need to contact the Health Plan (or MedImpact for Part D) directly using one of these methods. The same person who made the first decision will not review your reconsideration request. The Health Plan will investigate and provide a response to you. Please be aware they may call you to obtain more details and notify you of the outcome.'

See next slide for transmission methods.

Transmit the Appeal request to Advantage D-SNP Grievance & Appeals Department

Non-Contracted Providers may submit appeals by:

Members may submit appeals by:

Method	Part C (including Part B drugs)	Part D
Email	Grievances@hpsj.com	
Fax	1-209-942-6355	1-858-790-6060
Phone	1-888-361-PLAN (7526) or TTY 711	1-833-546-0796
Online	https://www.hpsj-mvjp.org	https://www.hpsj-mvjp.org
Mail (for enrollees only)*	Health Plan of San Joaquin 7751 South Manthey French Camp, CA 95231-9802	

Understand the Appeals process at Health Plan & MedImpact

Categorize appeal request as expedited or standard –

An appeal will be expedited when:

A physician makes a request or supports a member's request for an expedited appeal and indicates that applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function (the physician does not have to use these exact words).

An expedited appeal requested by the member/member's representative may be downgraded to standard. Member/member's representative will be notified if the appeal is downgraded by Health Plan or MedImpact.

Resolution timeframe is based on categorization and the type of request: Part B drugs, Part C, or Part D.

Understand the Appeals process at Health Plan & MedImpact – Cont.

Acknowledge receipt of appeal with submitter

Investigate details of case

- May contact provider or enrollee for additional context, information
- Outreach to provider, vendor, or FDR by Request for Response letter
    - Includes a summary of the appeal including reference to organization determination or coverage determination
    - Asks probing questions for additional detail
    - Requests response by a date specified
    - Identifies how to return responses – fax or email
- Outreach to internal departments as needed to obtain additional information.
- Complete investigation phase

Prepare and document resolution

Deliver written resolution to provider or member. To meet timeframes, resolution may be provided verbally in addition to the written notice.

Understand Provider responsibilities for responding to Appeal

Receive and promptly review request for response letter

- Provide a summary of your understanding of the situation and add context:
  - For member appeals:
    - Who provided information to the member in this situation?
    - What information was shared with member by provider?
    - What alternatives if any were offered?
    - What was the outcome of the situation from your point of view?
  - For provider appeals:
    - What is the basis for the member meeting criteria for additional days inpatient?
    - What is the fee basis for your request?
- Respond to detailed questions included in the request for response letter.
- Include any attachments which may help clarify the situation or resolve the issue.
- Return response within the requested timeframe.

NOTE: The Grievance & Appeals staff may outreach via phone for expedited appeals.

Quick Reference

APPEALS – Send Part B Drugs & Part C to HPSJ/MVHP. Send Part D to MedImpact.					
Category	**Request type**	**Who can request**	**Submission method**	**Resolution Timeframe**	**Response method**
Expedited	Part C (includes Part B drugs) & Part D	Member, Member's authorized representative, provider on behalf of member, or Non-contracted provider	Verbal or written	72 hours	Verbal and written
Standard	Part B Drugs or Part D			7 calendar days	Written
Standard	Part C			30 calendar days	Written

Regulatory references

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance:

2024 Medicare Managed Care and Part D Appeals Guidance – Nov 28, 2024
https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

D-SNPs: Integration & Unified Appeals & Grievance Requirements
ttps://www.cms.gov/medicare/medicaid-coordination/about/dsnps

Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
https://www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf

Health Plan of San Joaquin
Mountain Valley Health Plan

CLAIMS INFORMATION, SUBMISSION, AND PROVIDER DISPUTES

DHCS vs. D-SNP Basics

- D-SNP: Medicare is always primary
- DHCS: Medi-Cal is secondary payer.
  Except for Medi-Cal only (Medicare non-covered) Covered Services

Billing rules differ depending on primary payer

Billing – DHCS

Outpatient Billing:

- Follows Medi-Cal Outpatient Fee Schedule
- Uses Medi-Cal coding and billing rules

Inpatient Billing:

- Uses Medi-Cal DRG methodologies

SNF Billing:

- Per-diem reimbursement per Medi-Cal fee schedule
- APL 24-009 applies (https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-009.pdf)

For more information go to https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references

Billing – D-SNP

Outpatient Billing:

- Reimbursed under OPPS (Medicare)
- Includes partial hospitalization, IPPE, Hepatitis B vaccines, splints/casts
- Refer to Medicare Claims Processing Manual, https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912

Inpatient Billing:

- Reimbursed under IPPS (Medicare DRG system)
- Refer to Inpatient Hospital Billing Guide – Noridian JE Part A, https://med.noridianmedicare.com/web/jea/provider-types/acute-ipps-hospital/inpatient-hospital-billing-guide

SNF Billing:

- Uses PDPM (Medicare Part A)
- Requires HIPPS coding
- Refer to Noridian SNF Billing Guide, https://med.noridianmedicare.com/web/jea/provider-types/snf

Resources

- Medicare Coding & Billing: https://www.cms.gov/
- Medicare Payments https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient

Coding Requirements

- DHCS: Medi-Cal codes, Local X/Z codes allowed
- D-SNP: Must follow Medicare rules, no X/Z local codes
- Modifiers and Place of Service (POS) must match Medicare claim

COB (Coordination of Benefits)

- DHCS: pays full Medi-Cal charge
- D-SNP: Medicare pays first, Medi-Cal covers cost-share per APL 13-003
  https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-003.pdf

Key Provider Tips

- Do not use Medi-Cal local codes for D-SNP members
- Follow Medicare coding rules for D-SNP billing
- Ensure claims match Medicare adjudication exactly

Claim Submission
Basic Requirements § 424.32

A claim must meet the following requirements:

(1) A claim must be filed with the appropriate form prescribed by CMS in accordance with CMS instructions.

(2) A claim must include appropriate diagnostic coding for services using ICD-10-CM.

(3) A claim must be filed within the time limits of one calendar year of date of service. (§ 424.44)

Exceptions:

- At time the service was furnished the member was not entitled to Medicare.
- The member subsequently received notification of Medicare entitlement retroactively to or before the date of the furnished service.

(4) All Part B claims for services furnished to SNF residents (whether filed by the SNF or by another entity) must include the SNF's Medicare provider number and appropriate HCPCS coding.

Claims Electronic Data Interchange (EDI) Submission

Claims must be submitted to Health Plan on the CMS 1500, UBO4, or submitted via Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) claims must be submitted through **Office Ally and WayStar**

Office Ally
Payer ID: HPSJ1
(866) 575-4120
info@officeally.com
support@officeally.com

Office Ally Enrollment Resources:
Enrollments Department 360-975-7000
Option 3
enrollmentadmin@officeally.com
https://cms.officeally.com/Register/Register.aspx
https://player.vimeo.com/video/269695928

WayStar
Payer ID: HPSJ2
Main WayStar: 844-816-0524
Physician practices & other organizations:
844-392-9782
https://www.waystar.com/

Claims Paper Submission

Claims must be submitted to Advantage D-SNP on a CMS 1500 or UBO4 Form.

Claims can be submitted by paper if EDI is not your choice of claims submission.

Claims Mailing Address:
P.O Box 211395 Eagan, MN 55121-2195

Health Plan will acknowledge receipt of electronic claims within (2) working days and acknowledge receipt of paper claims within (15) working days.

Note: Before submitting a claim, verify the member's eligibility (the Eligibility Verification process can be referenced in the Provider Manual, Section 6: Eligibility, Enrollment, and Disenrollment.

Clean Claim vs Unclean (Other-than-Clean Claim)

Clean Claim: As defined at 42 CFR §422.500(b), a claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with 42 CFR §422.310(d)), or particular circumstance requiring special treatment that prevents timely payment and that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare

Unclean Claim: "Other-than-clean" claims require investigation or development external to the contractor's Medicare operation on a prepayment basis. If any required fields are missing, the Plan should make reasonable and diligent efforts to obtain the information. Additional information requests (AIR) should be made to the provider for the following scenarios: 1) Incomplete Claim, 2) Misc. Missing Info. 3) Correct Coding 4) No authorization 5) OHC

Other-than-"Clean" Claims

- Only one attempt is required to obtain the additional information
- Plan may deny the claim if unable to obtain required information within 45 calendar days

2024 Medicare C D Appeals Guidance Update

Timely Payment

- **Clean Claims**: 95% of clean claims must be paid in 30 calendar days.
- **Other-than-Clean Claims**: must be paid or denied within 60 calendar days.
- **Interest Payments**: Begins 31st/61st day of receipt of claim. Rate based on the current treasury rate and is updated semi-annually Front page | U.S. Department of the Treasury.

Merit-based Incentive Payment/Reductions (MIPS)

The Merit-based incentive payment is applied to provider services which appear on the Medicare Physician Fee Schedule, have a qualifying professional specialty, and have an NPI either by group or individual which appears on the MIPS report received annually from CMS via HPMS.

MIPS Positive Adjustments will apply to Contracted/Participating Providers.

MIPS Negative Adjustments will apply to Contracted/Participating & Non-Contracted/Non-Participating Providers.

The amount of the adjustment positive or negative should appear in the Provider Remittance Advice.

Sequestration

The Budget Control Act of 2011 requires mandatory across-the-board reductions in Federal spending known as sequestration. In the claims payment process sequestration is a percentage deduction applied to Medicare D-SNP claims payments to providers after MIPS payment adjustment and before interest is calculated(when applicable).

Note: *if benefit is only covered under Medi-Cal and is being paid using Medi-Cal funds, sequestration is not applicable*

Sequestration is currently calculated as 2% of the net payment amount after MIPS and any member liability amounts are reduced from the Medicare allowed amount.

The adjustment reason code (CARC) will appear in the Provider Remittance Advice with Remit Description 'Sequestration – reduction in federal payment'

Claim Adjustments

Claim adjustments are classified as

- **REOPENS,**
- **PROVIDER DISPUTES, or**
- **RECONSIDERATIONS**

Reopens

A reopen may be a plan-initiated or requested by a provider when:

- A clerical error, minor error, or omission has been made on the claim.
- Additional Information Request is received after the initial claim has been denied and the AIR is received within 120 calendar days of the original AIR claim closing.

Remit Message: Reason for adjustment will be applied to the claim and present on the remittance advice.

Provider Dispute Resolution

A provider dispute is requested by a provider when:

- The non-contracted provider asserts that the amount paid is less than the amount which would have been paid under original Medicare.
- The contracted provider disputes the organization determination for any reason.

Remit Message: Reason for adjustment will be applied to the claim and present on the remittance advice.

Reconsiderations/Appeals

A reconsideration may be requested by a non-contracted provider:

- A claim is fully or partially denied.
- The disputed amount is unrelated to the amount which would have been paid under original Medicare

Remit Message: Reason for adjustment will be applied to the claim and present on the remittance advice.

Timely Submission

From date of the remittance advice on the initial organization determination.

- Reopen Requests: 120 calendar days
- Reconsideration/Non-Contracted Provider Appeals: 65 calendar days
- Provider Disputes: 120 calendar days

Provider Dispute Resolution/Reconsiderations/Appeals Submission

May be submitted via Provider Portal or Mailed with appropriate form.

Provider Information

- ❑ Rendering Provider/Facility Name
- ❑ NPI
- ❑ Pay To Affiliate Name
- ❑ Provider Billing Address
- ❑ Contact Name & Phone Number

Member Information

- ❑ Patient Name
- ❑ Health Plan ID#
- ❑ Patient's Date of Birth
- ❑ Patient Account Number

Claim Information

- ❑ Health Plan issued claim number

Description of what is being disputed or requested for reconsideration.

Remittance Advice

Remittance advice notice will clearly communicate the services requested and the determination by including:

- Member name and identification number.
- Service provider name.
- Date(s) of service.
- Service codes and modifiers (CPT, HCCPS, revenue, HIPPS).
- Amount allowed for the service.
- Member responsibility amounts (copay, coinsurance).
- Adjustment amounts and reason for adjustments (MIPS, Interest, NCCI, etc.)
- Adjustment/Denial reason.
- Payment amount.
- Payment date.
- Check number.
- Dispute & Appeals Rights Language will be included

835 Electronic Remittance Advice (ERA) Files

Health Plan is pleased to announce an important update to the distribution process of the 835 Electronic Remittance Advice (ERA) files. We now have implemented an automated process to streamline the delivery of 835 files using Smart Data Solutions (SDS).
This enhancement will ensure that you receive your 835 files faster and more efficiently. The new process operates as follows:

Regular Check Run:
After each check run, your 835 files are automatically generated and distributed to our clearinghouse partner, SDS. To receive your 835 files, instructions are below:

•**If you want to use SDS:** Reach out to your existing clearinghouse vendor and ask them to add connection to SDS for Health Plan under Payer Enrollment using **Payer ID: 68035** or visit sdata.us and select the Provider Portal link at the top of the webpage. Once there, you can log in if you have an account or you can register for a new account.

For the SDS Provider Portal Companion Guide, you can access it here https://sdata.us/what-we-do/clearinghouse/smart-data-stream-provider-portal/.

We have also partnered with another clearinghouse, TriZetto/Cognizant, who can deliver 835 files to those who are already signed up or choose to sign up with them as their clearinghouse.

•**If you want to use TriZetto:** You must be signed up with TriZetto before Health Plan can deliver your 835 files. For new users and to sign up, visit:

https://www.trizettoprovider.com/health-plan-of-san-joaquin-new-user-form. For existing users, please contact TriZetto to arrange delivery of 835 files from Health Plan.

Remittance Advice (RA) & Explanation of Payment (EOP)

Providers have the ability to access their payment details through the provider portal, Doctors Referral Express (DRE).

If you are not already a DRE user, please sign up by completing the form found here: https://hpsj4.wpengine.com/wp-content/uploads/2019/03/DRE_Confidentiality_Statement_Form.pdf.

Please fax the completed form to the Provider Services Department at (209) 461-2565.

Remittance Advice (RA) & Explanation of Payment (EOP)

DRE user, no action is needed. Below are instructions on how to navigate to the RA tool via DRE.

1.Click the *Remittance Advice* link on the left panel.

2.Select the appropriate filters to download your RA for your specific check program.

Select the Check Run Program that applies:

- Capitation (CAP) (monthly)
- FFS (twice per week)
- Proposition 56 (monthly)
- Value Based Payment (VBP) (monthly)

Coverage Determination Notices

A Coverage Determination Notice will be sent to a member, or a member's representative, for any partially paid or fully denied services when:

1. Request submitted by a member or member representative.
2. Services provided by a non-contracted provider.

DRE

DRE Link https://provider.hpsj.com/public/acctdre/default.aspx

- Providers can request access on or after the contract's effective date.
- Provider Portal is available 24 hours a day, 7 days a week, and is HIPAA compliant.

DRE Claim Portal – Claims Visibility

- View Auth Number associated w/claim billed
- Claim denial code populated w/ description- RA
- Reference Original Claim associated with A1 claim
- From-Through dates of claim
- Revenue codes
- Modifiers
- NDC Number for Drugs
- Billed Units

Provider Manual – Claims Information

Health Plan of San Joaquin provides comprehensive information on the following sections of the Provider Manual:

- Section 10: Claims Submission
  This includes Member Billing prohibition
  https://www.hpsj.com/

- Section 11: Provider Payment
  https://www.hpsj.com/

- Section 12: Dispute Resolution
  https://www.hpsj.com/

Resources

1. Medicare Claims Processing Manual
   - Medicare Claims Processing Manual
2. Noridian Provider Guides (JE Part A/Part B)
   - Inpatient Hospital Billing Guide - JE Part A - Noridian
3. DHCS Manuals (https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Medi-CalProviderManuals.aspx) and
4. All Plan Letters (APLs) (https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx)

Contact Information

Provider Services

- Email: providerservices@hpsj.com
- Call Customer Service: 209-942-6340
  or toll free at 888-361-7526

Ask to speak to a Provider Services Representative

Questions

THANK YOU!

Health Plan of San Joaquin | Mountain Valley Health Plan

www.hpsj-mvhp.org | 1-888-936-PLAN (7526)

San Joaquin

HPSJ/MVHP Headquarters
7751 South Manthey Road
French Camp, CA 95231

Stanislaus

1025 J Street
Modesto, CA 95354

El Dorado

4237 Golden Circle Drive
Placerville, CA 95667